

## **ADDENDUM TO CLIENT INFORMATION AND INFORMED CONSENT FOR DISTANCE THERAPY**

### *Distance Therapy*

Distance therapy includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications.

### *Identity Verification*

You will be expected to provide a copy of your driver's license and other identity verifying documentation requested by the undersigned therapist before any distance therapy services are provided.

### *Privacy and Security of Communications*

All electronic communications between you and the undersigned therapist will be transmitted using the encryption software referenced in the *Consent to Treatment* section below. You will be responsible to secure and protect the functionality, integrity and privacy of your hardware, files and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned therapist when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

### *Risks Associated with Distance Therapy*

There are privacy and security risks and consequences associated with distance therapy despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in distance counseling and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by unauthorized third party despite the reasonable efforts of the undersigned therapist to arrange a secure line of communication.

Distance therapy services and care may not be as complete or effective as face-to-face services. The undersigned therapist will continually assess the appropriateness of

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distance therapy for you. If the undersigned therapist determines that you would be better served by receiving different therapeutic services such as face-to-face counseling, recommendations for treatment and treatment providers or facilities will be provided to you.

*Communication Interruptions*

If you are unable to connect with the undersigned therapist or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible the undersigned therapist can be reached at the following phone number: 972-680-8986 Ext. 307.

*Consent to Treatment*

I, voluntarily, agree to receive synchronous assessment, care, treatment and services through the use of the following technologies: (Vsee ) and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

By signing this Addendum to Client Information and Consent to Treat, I, the undersigned client, acknowledge that I have read, understood and agreed to be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_  
(If patient is under age 18)

Date: \_\_\_\_\_

Therapist: \_\_\_\_\_

Date: \_\_\_\_\_